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## Initiatives to Control Military Health Costs

SUSAN HOSEK

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Testimony presented to the Senate Committee on Armed Services,  
Subcommittee on Personnel on April 21, 2005

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**The RAND Corporation**

**Before the Committee on Armed Services**  
**Subcommittee on Personnel**  
**United States Senate**

**April 21, 2005**

Chairman Graham and distinguished members of the Committee, thank you for inviting me to testify today on present and future costs of defense health care. It is an honor and pleasure to be here.

My testimony will briefly discuss cost trends in Defense health care and then focus on two areas in which the Department of Defense might consider making changes: (1) TRICARE benefit design and (2) organizational structure of the Military Health System.

**Defense Health Care Cost Trends**

Through TRICARE, DoD provides a comprehensive health benefit to active duty personnel and their dependents. With the addition of TRICARE for Life, this is now a lifetime benefit for those who make the military a career. A continuous benefit is now being offered to reservists who have been called to active duty since September 11, 2001.

The health benefit grew out of a policy of granting dependents and retirees eligibility for care in military treatment facilities (MTFs) when they had space available after caring for active duty members. With the establishment of an employer-based health system in the U.S., a defined health benefit replaced space-available access for under-65 beneficiaries and CHAMPUS was established to finance any care military providers couldn't handle. TRICARE modernized the delivery of the benefit by

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<sup>1</sup> The opinions and conclusions expressed in this testimony are the author's alone and should not be interpreted as representing those of RAND or any of the sponsors of its research. This product is part of the RAND Corporation testimony series. RAND testimonies record testimony presented by RAND associates to federal, state, or local legislative committees; government-appointed commissions and panels; and private review and oversight bodies. The RAND Corporation is a nonprofit research organization providing objective analysis and effective solutions that address the challenges facing the public and private sectors around the world. RAND's publications do not necessarily reflect the opinions of its research clients and sponsors.

integrating management of MTF care and CHAMPUS-financed civilian care by adding an HMO option (Prime) and a PPO option (Extra) to the Standard fee-for-service option, partnering with civilian health-care companies, and improving access to care. Today, TRICARE compares favorably with civilian health plans on many measures, and military members clearly consider it to be an important element of their compensation package and a visible marker of the support and appreciation for their service to the nation.

Like all public and private payers, DoD has experienced unrelenting, significant growth in the costs of its health benefit. DoD's inflation-adjusted per capita health-care costs increased just under 4 percent per year from 1988 to 2003 (excluding costs for TRICARE for Life). This is approximately the same real rate of increase experienced in the civilian sector during the same 15-year period. Moreover, this has been the long-term rate of increase in health costs for the past five decades.<sup>2</sup> So DoD's health system is simply on the same path as the U.S. health care system overall.

Can anything be done to curb cost growth in the future? Civilian employers have resorted to benefit cuts to control costs, shifting some costs to their employees and hoping that higher cost sharing will induce lower spending. Economic research has consistently shown that increases in health costs are offset by lower wages in the civilian labor market.

In contrast to the private sector, DoD has expanded its benefits in recent years, eliminating almost all cost sharing for active-duty personnel and their family members if they are enrolled in Prime and adding TRICARE for Life to supplement Medicare coverage for beneficiaries over age 65. As I describe below, TRICARE today is a more attractive option than employer health plans for most of the beneficiaries who are eligible for both DoD and civilian employers' health plans. Most of these beneficiaries are military retirees who have a second career (and their spouses), but some active-duty spouses are also eligible for civilian-employer health benefits. If current trends continue, DoD risks becoming the primary insurer for all of its beneficiaries, picking up an even higher share of costs that would otherwise be covered by employer health plans. When costs merely shift from employers to DoD, the cost to DoD increases but there is little change in the value of the benefit to service members.

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<sup>2</sup> *Growth in Medical Spending by the Department of Defense*, Congressional Budget Office, 2003.; Cutler, D. M., M. McClellan, et al., "What Has Increased Medical-Care Spending Brought?," *American Economic Review*, Vol. 88, No. 2, Pg. 132-136, 1998.

Health services researchers agree that the long-run trend toward higher health-care costs largely reflects advances in medical technology, but there is little evidence on the health payoff from these advances. A recent RAND study found that approximately half of the health care delivered in the U.S. is inappropriate.<sup>3</sup> Medicare and other major payers are exploring new mechanisms for targeting health care dollars on a more appropriate mix of services. DoD's current organizational structure, with its parallel management structures in OSD and the services, is not ideal for undertaking this kind of complex health management initiative.

### **Design of the TRICARE Benefit**

Overall, TRICARE benefits compare favorably with benefits in private-sector plans. Cost sharing is about the same for downtown office visits and MTF care is free; TRICARE premiums and TRICARE pharmaceutical cost sharing are lower. For beneficiaries who are eligible for employer benefits, the big difference is in the premium contribution required for TRICARE versus their employer's plan. Differences in beneficiary cost sharing for covered services are smaller and the services covered are fairly similar.

The average annual premium contribution for family coverage in employer plans was \$2,661 in 2004, and there was little difference between HMO and non-HMO plans. TRICARE requires no premium contribution, except for retirees who elect to enroll in Prime, the HMO option.<sup>4</sup> Family coverage cost them only \$460 in 2004—the amount established when TRICARE was implemented almost a decade ago. This difference in premium cost will continue to grow over time unless TRICARE premiums are increased.

Undoubtedly as a result of this “premium gap,” relatively few TRICARE beneficiaries employed in the private sector are covered by employer health plans. Currently, DoD surveys do not support estimates of how many beneficiaries are

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<sup>3</sup>McGlynn, E. A., S. M. Asch, et al., "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine*, Vol. 348, No. 26, Pg. 2635-2645, 2003. The study evaluated the quality of care for a random sample of adults living in 12 metropolitan areas. It measured performance on 439 indicators of quality of care for 30 acute and chronic conditions as well as preventive care. Overall, participants received 54.9 percent (95 percent confidence interval, 54.3 to 55.5) of recommended care.

<sup>4</sup> The new TRICARE Reserve Select program requires a premium contribution of \$2796.

foregoing employer insurance for which they are eligible. But we can infer that this behavior is probably widespread by looking at military retirees who are under age 65 and working full-time. In 2002, 72 percent of these retirees worked for employers providing health insurance. Among those with access to an employer health plan, 35 percent paid to enroll in TRICARE Prime and 62 percent sought care through some TRICARE option.

Focusing on families, when a military beneficiary gives up employer insurance and uses TRICARE, the employer saves about \$7200 a year and the employee saves over \$2000. DoD assumes both costs. So much of the DoD benefit accrues to the employer instead of the retiree. Eliminating or reducing the TRICARE premium gap for under-65 retirees and dependents would induce more retirees to participate in their employer plans, but it would represent a significant benefit cut and lead to the possibility that some military retirees without access to employer benefits would become uninsured.

A more promising approach is to offer a new benefit that retirees can choose in lieu of TRICARE and use to cover premiums and out-of-pocket costs in employer plans. This new benefit might take the form of a Health Savings Account. Making a simplistic calculation, DoD can cover the \$2000 premium contribution and make \$7000 on the exchange. But some retirees who forego TRICARE now will take advantage of this new benefit, offsetting at least some of the cost savings from prior TRICARE users. There are other benefits that could be offered to induce beneficiaries to enroll in and rely on their employer plans. More information is needed to determine whether any of these approaches would realize significant savings, how retirees would react to the idea, and how to design the most cost-effective approach for both DoD and retirees. The potential of this general approach is such that an investment in information and analysis is warranted.

As I indicated earlier, out-of-pocket costs for getting care from civilian providers are similar in TRICARE and other employer plans. For example, the typical HMO plan charges a \$15 visit fee whereas TRICARE Prime has no fee for active-duty dependents and a \$12 fee for retirees and their dependents. Most non-HMO employer plans also rely on a visit fee—typically \$20 for a provider under contract to the plan—which is likely to be just below what the 15-20 percent cost sharing costs beneficiaries in Extra.<sup>5</sup> But TRICARE only charges for care delivered by civilian providers; MTF care is free of

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<sup>5</sup> Information on employer plans comes from *Employer Health Benefits: 2004 Annual Survey*, Kaiser Family Foundation and Health Research and Educational Trust, 2004.



charge. Introducing a copayment for MTF visits has been suggested before and while it would reduce outpatient utilization, overall cost savings are likely to be modest.

However, employer plans typically charge twice what TRICARE does for prescription drugs. TRICARE charges \$3 for a generic drug and \$9 for a brand-name drug, whereas employer plans typically charge \$10 and \$20, respectively. Also, as with other services, many military beneficiaries have access to free prescriptions in the MTFs. A recent RAND study showed that people are highly responsive to the price they pay for prescriptions.<sup>6</sup> Updating prescription copayments to employer-plan levels would likely lead to noticeable cost savings in TRICARE, provided that the copayments applied to prescriptions filled by the MTFs, not just civilian pharmacies.

To summarize, the TRICARE benefit is more attractive than the benefit offered by most civilian employers and, as a result, many retirees appear to be relying on TRICARE instead of their employer's plans. Rather than reduce TRICARE benefits to private-sector levels, it may be possible to induce retirees to take full advantage of any employer benefits for which they are eligible by offering to offset their higher out-of-pocket costs. This would ensure that DoD's spending on health care benefited its beneficiaries, rather than their employers. Some modest changes in cost sharing for care may also be worth considering.

### **Organization of the Military Health System**

The second area where changes could impact trends in costs is the organization of the Military Health System. My comments on organization are based on a 2001 RAND report on creating a joint medical command and organization of the military health system more generally.<sup>7</sup> This study drew on organizational models from the civilian sector and within the DoD to develop and assess organizational alternatives. Although we paid careful attention to the evidence on effective organizational approaches, we also

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<sup>6</sup>Increasing the price from \$5 to \$14 for a generic drug and from \$10 to \$20 for a brand-name drug reduced spending by 33 percent. The largest decreases were for drugs that have close over-the-counter substitutes; higher prices caused smaller reductions in the use of drugs that don't have substitutes and are important in controlling chronic illness. Joyce, G. F., J. J. Escarce, et al., "Employer Drug Benefit Plans and Spending on Prescription Drugs," *JAMA*, Vol. 288, No. 14, Pg. 1733-1739, 2002, Goldman, D. P., G. F. Joyce, et al., "Pharmacy Benefits and the Use of Drugs by the Chronically Ill," *JAMA*, Vol. 291, No. 19, Pg. 2344-2350, 2004.

<sup>7</sup> Hosek, S. D. and G. Cecchine, *Reorganizing the Military Health System: Should There Be a Joint Command?*, RAND Corporation, MR-1350-OSD, 2001.

considered how the coordination required between operational medical support and providing TRICARE services might be accomplished under the alternatives we identified.

Consistent with basic principles of organizational design, civilian health-care organizations consolidate authority and responsibility in single market managers, who report through a regional chain of command to corporate management. Since experience has shown that there can be a conflict of interest, management of the health plan is separated from management of the providers when they are not separately owned.<sup>8</sup> Accountability is maintained through the strategic planning and evaluation processes, which set specific financial and non-financial goals. Management information systems are tailored to support planning and evaluation, and strong incentives are established and aligned with goals.

TRICARE management has taken steps that reflect these standard private-sector practices. However, we concluded that a single chain of command for TRICARE management, separate from the MTF command structure, would create the clear lines of authority and accountability that characterize the private sector. Arguably, the same principles might apply in operational medicine as well, but our study did not investigate the management challenges associated with the readiness mission. We did consider how readiness considerations might alter our conclusions about organizational effectiveness for the benefits mission (TRICARE).

We identified four alternative organizational structures that consolidate authority over some or all of the system. The first alternative would consolidate TRICARE authority within the current structure by modifying resource management and accountability. The resources used to deliver care to TRICARE beneficiaries would flow through TMA to a group of local market managers, who would reimburse the services for MTF care and the contractors for civilian care. TMA and its local market managers would be accountable for overall TRICARE outcomes and the services would be accountable for the care they provide. The other three alternative structures establish a joint medical command, but they differ in how they structure the command. One establishes a joint command over the organizational structure I just described. Another maintains three Service component commands, each responsible for medical readiness activities within its Service and for managing all health care provided for its defined

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<sup>8</sup> In the Military Health System, TRICARE is the health plan and the MTFs are providers.

population. TMA would be largely disbanded under this scheme. A third joint command alternative organizes two joint chains of command, one for readiness and the other for TRICARE. The MTFs would be managed through the TRICARE chain. All of these organizational schemes, including the current one, require development of an efficient mechanism for shifting personnel and other resources between readiness and TRICARE.

We could not be certain which of these alternatives would out-perform the others. But we could conclude that any of the alternative organizations we identified, which would consolidate authority over TRICARE resources and establish clear accountability for outcomes, should out-perform the current organization, which lacks these characteristics. We further concluded that establishing a joint medical command over the current structure, without making these other organizational changes, likely would not be as effective. In short, we concurred with at least a dozen other major studies of military health-care organization, conducted over six decades, that more consolidated management would be advantageous but we also recommended a package of changes that would reflect best organizational practices.

## **Conclusion**

Outside TRICARE for Life, the long-term trend in Defense health costs reflects the trend in health costs in the U.S. and many other countries. In light of the persistence of this trend over many decades, it can be expected to continue into the future. But there are potential opportunities to shift the cost line downwards. Asking beneficiaries to pay when they get care would lead to decreased utilization and costs, but high cost sharing would also represent a benefit cut—a difficult action to contemplate now. Adding new benefit options that would offer beneficiaries the option of using employer health plans without incurring substantially higher premium costs could result in gains for both beneficiaries and DoD. As the U.S. health system continues to search for ways to curb costs and/or improve health outcomes, DoD should reconsider its health-care organization so that it can readily adapt new approaches and create some itself.

Thank you for the opportunity to contribute to the debate regarding Defense health care costs. I am happy to answer questions from the committee.